

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Your History & Medical Information**

1. Are you here today for a toenail fungus problem? ( ) Yes ( ) NO
2. Which toenails are infected with fungus? Check all that you suspect.  
LEFT: ( ) 5, ( ) 4, ( ) 3, ( ) 2, ( ) Big toe    RIGHT: ( ) Big toe, ( ) 2, ( ) 3, ( ) 4, ( ) 5
3. How long have you had this problem? \_\_\_\_\_ (Months) (Years)
4. Has this condition been treated before? ( ) Yes ( ) No
5. Check all that you have used or tried:  
 Lamisil Pills                       Penlac Paint                       Diflucan Pills                       Nizoral Pills  
 Griseofulvin Pills     Sporanox Pills                       Fungus Cream, Lotion or Spray: \_\_\_\_\_
6. When did you use it? \_\_\_\_\_ For how long? \_\_\_\_\_ Last time used: \_\_\_\_\_
7. Do you have? (Circle all that apply to you) ( ) None  

Diabetes	High Blood Pressure	Neurologic	Bleeding
Epilepsy	Lung Disorder	Stroke	Psoriasis
Heart Disease	Nerve Disorder	HIV/AIDS	Other _____
8. List any other medications you are now taking: ( ) None  
 \_\_\_\_\_
9. Are you allergic to: (Circle all that apply to you) ( ) None  

Penicillin	Aspirin	Sulfa drugs	Narcotics/ Codeine
Latex	Anesthesia	Skin Medicine	Other _____
10. Do you exercise? If so, how often and what type of exercise do you do? \_\_\_\_\_
11. Do you attend Nail Salons for pedicures? If so, how often? \_\_\_\_\_
12. Do you have any other foot problems? If so, what are they? \_\_\_\_\_

